

EOB Codes and Descriptions

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- | | |
|-----|---|
| 001 | this fee was adjusted to the maximum allowable. |
| 002 | claim indicates 1c mod (baby). There is no indication of baby in the correct field and/or twin a/b or triplbett a/b/c. Rebill w/appropriate information. Valid codes are 99201-99215, remove 1c mod if necessary. |
| 003 | This adjusted claim or detail line has been reimbursed under the trauma program at the previously paid allowed amount. No additional trauma enhanced payment was allowed. Adj - per rcn # 4162 |
| 004 | the extension dates do not cover the dates of service or the number of days beyond the ita length of stay limitations. |
| 007 | report/x-rays are required to substantiate the fee for services billed. |
| 009 | the (7 digit) prescribing provider number is missing or invalid. Please refer to your billing instructions |
| 010 | we are unable to identify the client per the HIC submitted by Medicare/pic submitted on claim. If this is a DSHS client, rebill with the complete DSHS patient id code and Medicare RA. |
| 011 | this client is not eligible for this date of service. |
| 012 | A minimum of 8 hours and a maximum of 24 hours during a 24 hour day are required to meet the criteria for continuous home care. |
| 013 | the provider file indicates the provider is deceased. |
| 014 | please indicate the place of service. Bill only single digit place of service (1,2,3,4,5,6,7,8 or 9) on claims billed to medicaid. See billing instructions for specific details. |
| 015 | unable to verify eligibility for this patient. Patient id code (PIC) is missing, incomplete, incorrect or in the wrong location on your claim. Please refer to your billing instructions for correct billing procedures 000,129,130,250 |
| 016 | the recipient's name and/or the admit date on the extension request does not match the claim information. Please correct and resubmit. |
| 017 | the diagnosis is not appropriate with the procedure billed. Please refer to your billing instructions. |
| 018 | claim/resubmission received beyond billing limit time period allowed by state law or the resubmission icn/information supplied does not verify timeliness for the original claim. |
| 019 | this procedure has been denied as a separate procedure as indicated in CPT and modifier 59 was not used. See your CPT for direction. |
| 020 | service requires auth. Enter the auth. # in the appropriate field. Call 1-800-634-1398 for hosp admits/mri or short stay; 1-800-292-8064 for dme/prosthetics/orthotics. |
| 023 | service requires prior authorization. For approval call: hospital admits /short stays/mri's 1-360-725-1584. Dme/prosthetics/orthotics 1-800-292-8064. Dental & all else - see your billing instructions. |
| 025 | only one depo-provera contraceptive injection allowed in a 65 day period lunelle not allowed if less than 23 days apart. |
| 026 | this adjusted claim or detail line has been reimbursed under the trauma program. |
| 027 | the allowance of orthodontia treatment for 3 months has already been met. |
| 028 | this drug is included in nursing home/imr cost reimbursement rate. |
| 029 | this pic should be used (in the appropriate field) on future billings for this client to avoid delay in processing. |
| 030 | the Medicare payment exceeds the DSHS allowable fee. |
| 031 | this has been paid in part by other insurance. |

032 the insurance payment exceeds the DSHS allowable fee or Medicare calculated deductible and/or coinsurance. If you have questions, please call 1-800-562-6136.

034 the allowance for orthodontia treatment has already been met.

035 this is a restricted client & this claim requires the appropriate provider # for date(s) of service on claim. Refer to your DSHS general info booklet or call 1-800-562-6188 for restricted or hospice clients.

036 the modifier(s) are invalid/missing/inappropriate for this procedure, this place of service, the date of service or you may need a special agreement. Please refer to your billing instructions.

037 the secondary diagnosis code on the claim is invalid. Please correct and resubmit.

038 the referring provider number is missing, invalid, or is a self-referral. Please see your billing instructions.

039 the third diagnosis code is invalid. Please correct this and resubmit.

040 the 4th diagnosis is invalid. Please correct this and resubmit.

041 this is a duplicate of claim or service previously paid.

042 this is a duplicate of claim or service that is currently in process.

043 this claim has been forwarded to the nursing care consultant, please do not rebill.

044 the 5th diagnosis code is invalid. Please correct this and resubmit.

045 the performing provider number is missing or not in the appropriate box on your claim form. Refer to your billing instructions.

046 the claim reimbursement has been reduced by the amount indicated in the patient liability.

047 this revenue code is not routinely covered by DSHS or is not covered for this provider number and/or provider type. Please refer to your billing instructions.

048 this claim is beyond the pas length of stay allowance. A pas extension request and complete medical records are required. Please refer to your billing instructions.

049 the dates of service do not equal the number of days billed. Please correct the admit date, discharge date, patient status code, and/or the number of days billed and resubmit.

050 this claim lacks daily room rate.

051 pharmacist reported due diligence at obtaining benefits, or patient's insurance is 100% prepay plan or 60 day long-term-care grace period is reported.

052 patient status is missing or invalid.

053 noncovered charge error.

055 this procedure/drug is invalid for this patient age/sex. Please refer to billing instructions.

056 only one date of service is allowed on an outpatient claim.

057 the attending provider number is missing or invalid.

058 the admit/dates of service do not match the stamp/ita form dates. Please correct and resubmit.

059 payment received from insurance company. Unable to apply correct amount refunded because of unrelated deductions on the same multi-refund check. Cash control info

060 our files do not indicate the patient is in a nursing home.

061 please bill part a charges to Medicare or resubmit with part a denial.

062 the primary procedure code is invalid. Please correct and resubmit.

063 the 2nd procedure code is invalid. Please correct and resubmit. 215, eob erroneously tied to 899, removed 10/27/00.

064 the 3rd procedure code is invalid. Please correct and resubmit.

065 missing or invalid patient status. Interim drg bills are only accepted when outlier status is met.

066 one x-ray for this area has already been allowed.

067 the surgery date is invalid or is not between the first and last dates of service.

068 our records indicate Medicare benefits are available. Please bill Medicare part b carrier or resubmit with
an original Medicare denial. If Medicare/managed care, please indicate on claim or comments/remarks.
069 client is on mi program and due to legislative mandate the mi program has ended 7/1/03.
070 drg 469, 470, 476, or 477 was assigned. Please resubmit claim after validation of the procedure codes or
diagnosis codes.
071 exceeds the psychiatric limitation for procedure code 90801.
072 the sterilization consent form is not on file or is invalid. Delete coding and charges related to
sterilizations.
073 this service is not provided on the gau program.
074 drg readmit payment denied per maa.
075 our records indicate that this client was deceased prior to the service date.
076 please check your beginning and/or ending dates of service. Services cannot be billed prior to the
date(s) services are rendered.
077 psychotherapy services is limited to one hour per month.
079 only services listed in the ambulatory surgery center fee schedule should be billed.
080 this performing provider number is not a valid individual medicaid identification number for the date(s)
of service on this claim.
081 this diagnosis, service, or drug is not payable under ita; or the client is under age 13 and the hospital
service is not payable under ita.
083 A surgery date was entered but no icd-9 procedure code was indicated.
084 our records indicate this provider voluntarily terminated this provider number.
085 missing or invalid admission source code (ub-92 form locator 20).
086 this service is not covered under the medically needy program.
087 claims for psychiatric services must indicate either voluntary or ita on the claim form. (ub-92 form
locator 84).
088 these services are covered by providence elder place (pace project) at 5900 martin luther king jr. Way
south, seattle, wa., phone number is (206) 320-5984.
089 the maximum of 40 units of mental health case management per calendar month has been met. No
comment
090 please bill your claim to the insurance company as instructed. For questions call 1-800-562-6136.
091 this client is not eligible--the medical id card, award letter or medical eligibility verification (mev)
printout does not cover the date(s) of service and/or this client.
092 drg 468, 476, or 477. The principle diagnosis is not supported by the documentation submitted. Please
recode and resubmit. Denial eob used by ncc's for exception 631
094 this service is not covered under the medically indigent program.
095 this was denied by Medicare. If this is a DSHS covered service & the medical id card does not indicate
"QMB-Medicare only" please rebill attaching your Medicare denial. Do not indicate the "x0" on your
claim.
096 to avoid delay in payment on future billings, please use the revised hcfa-1500 (u2)(12-90) claim form.
098 this is a duplicate premium payment. Mhc premium payment - duplicate pic adjustments
100 you have used a procedure code which is not designated for the epsdt- healthy kids program. Please refer
to your billing instructions.
101 the number of units billed has been adjusted to the maximum allowable.
102 According to our records this appears to be a duplicate of a claim or service.

103 this claim has been referred to the medical/dental/pharmacist consultant or mmis services or internal review. Direct calls to provider inquiry 1-800-562-6188.

104 procedures 81002, 81003 and 81015 are not allowed in combination with urinalysis procedure 81000.

105 the Medicare remittance report or eomb/hmo eob does not match the service/fees/dates/client for the service(s) billed.

106 services on this claim not allowed with same services or combination of services already paid to this provider # or performing provider # on another claim. Any questions, call provider inquiry -1-800-562-6188.

107 this patient is not responsible for the balance due on this claim.

108 this service is not payable under this provider number for date(s) of service billed.

109 either the remittance advice date, the icn, or the Medicare eomb process date is beyond the rebilling time limitation.

110 replacement dentures/partials require justification. Dentures replaced within a year require prior authorization. 1 lost denture replacement in a 10 year period. 1 lost partial replacement in a 5 year period.

111 multiple services not allowed because lt/rt modifiers not indicated or different times not stated.

115 the tooth number/quadrant is not required or appropriate for this procedure code.

116 no record/invalid authorization.call 1-800-634-1398 -hospital admits/mri /short stay; 1-800-292-8064 -dme/prosthetics/orthotics; 1-800-848-2842 - pharmacy med auth. Expedited authorization - see numbered memorandum.

118 the provider number is contingent upon a completed application. For information call 1-866-545-0544.

119 the date of service is missing or incorrect.

120 Administrative agreement - pip transaction. Cash control- harborview- sys gen 120 through 150

121 this claim has been identified as a failed pitocin induction. Resubmit as an outpatient claim.

122 court settlement. Cash control - m. Garrison

126 Administrative days have been separated from the daily room charges per medical review.

129 the procedure code was changed to hcpcs/state assigned --see your billing instructions. Please use this code to avoid future denials.

140 eligibility does not cover span of dates. Please list actual dates of service.

141 chip co-payment applied to this claim. System-generated when chip client co-pay deducted from claim

142 dates of service were changed and/or split, due to same or similar service previously paid to a different provider. If you have questions, contact pru at 1-800-562-6188.

147 this claim is being reviewed by the 3rd party liability unit. If you have questions, call 1-800-562-6136.

151 All capitated services/co-pays/deductibles are included in the premium paid under the hmo contract.

152 confirmation number required before submitting claim. See billing instructions. After receiving confirmation #, resubmit claim with number in box 23 on the hcfa 1500 form or prior auth field on electronics.

153 the revenue/procedure code is missing/nonallowable/inappropriate on your claim for the dates of service.

154 this provider number has been terminated. For questions call 1-866-545-0544.

155 your claim has been forwarded to the quality utilization section (qus).

157 this detail and/or claim did not indicate a charge to the department.

158 please refer to your fee schedule/billing instructions or CPT for correct billing procedure for the date of service billed. Any questions call provider inquiry at 1-800-562-6188.

161 our records indicate this service was previously paid under another procedure code per policy
guidelines.

162 missing estimated days supply or days supply allowed has been exceeded.

164 our records indicate we are paying Medicare premiums for this client. Please resubmit to Medicare.

166 the procedure(s) indicated on your claim does not require approval. Please refer to your billing
instructions.

167 this service exceeds speech therapy limitations.

168 the quantity of the item or service must be specified.

169 claim denied for non-compliance with client's mhc/hmo/managed Medicare plan provisions. The plan is
the primary payor. Please appeal this claim to them. If denied on the appeal rebill with a copy of the
denial. Loc 55

170 this service is not in accord with your special agreement. For information please call 1-800-562-6188.

171 provider number not on file.

172 Admission type is invalid. Please refer to your billing instructions.

173 occurrence codes 11-16 and j0 require a date in the occurrence code date field. Please correct and
resubmit.

175 this is the beginning of a new pregnancy.

176 unable to price for this date of service.

177 please show the individual dates of service on your claim. All dates of service per line must be in the
same calendar month.

178 this claim was paid or rejected per a dur alert.

179 only approved centers of excellence can bill transplant drg's 103, 302, 480, 795, 803, 804, or 805.

180 the service was billed on a date that is not considered an authorized holiday. Please refer to your billing
instructions.

181 An admit or evaluation and management has been previously paid to another provider or the same
provider on the same date of service.

184 the procedure is for routine newborn care but the diagnosis indicates illness or other than routine
newborn care. Please review 105

185 our files show the client is ineligible for medical services. Please rebill attaching a copy of the medical
id card. 279 med code 6 client (foster care or food stamp).

186 high drug dose alert.

187 only consecutive calls can be billed on 1 line. Please refer to your billing instructions.

189 An adjustment to the original/current claim shown in paid status on your remittance and status report is
necessary to process corrections, changes, or additional services. Resubmit on form 525-109.

190 please rebill with a report/medical records or charts to substantiate services/fees or time units billed.

191 your claim has been referred to provider enrollment. For information call (360) 725-1026, 725-1032,
725-1033, or 1-800-562-6188 and select option 1.

192 the date(s) of service on claim are "prior" to the provider enrollment effective date. If questions contact
provider enrollment (360) 725-1026, 725-1032, 725-1033 or 1-800-562-6188 and select option 1.

193 this client is only eligible for ita or blind services.

194 this client is only eligible for the detox program.

195 the service or services were not received by the client.

196 please rebill with an itemized invoice from the supplier for supplies dispensed for this billing.
Individual supplies must be clearly itemized and identified for each unit, package, etc. Billed.

197 there was a payment/processing delay due to inappropriate and/or unnecessary information in the
comment field. (info only) info only, 197

198 Auth pending. Call 1-800-292-8064 - dme/prosthetics/orthotics; 1-800-634-1398 - hosp admits/mri/short
stay.

199 invoice required for bridge/ferry tolls. Please rebill with invoice.

200 the provider's application has been denied.

201 this has been paid in part by Medicare or social security. Cash control, surs

202 payment for a surgical tray is included in the procedure.

204 low drug dose alert.

205 we cannot process this claim for payment as the Medicare rejection notice/denial is not dated.

206 the pic code on this claim does not match the pic code on the authorization number. For pharmacy call
1-800-848-2842 or dme call 1-800-292-8064.

207 invalid, missing or illegible primary icd-9 diagnosis code.

208 this ndc is not covered for nursing home clients.

209 this is included in the flat fee allowance for the tpen monthly supply/administration kit. Sur

210 out-of-state services are not provided on the gau or mi program.

211 managed care/Medicare is the primary distributor of funds. Please send any discrepancies, protests or
other information as requested to Medicare/managed Medicare.

212 procedure code is not payable in this place of service.

213 this claim was adjudicated in accord with medical authorization services mas sends ws downstairs.

214 therapeutic duplication alert.

216 the service date(s) billed exceed the days authorized by the prior authorization number.

217 our records indicate the department has paid the monthly premium covering this date of service. If you
have any questions please call provider relations at 1-800-562-6188.

218 please indicate the name of the licensed birthing facility where the delivery was performed and resubmit
your claim.

219 refill too soon.

220 claim paid according to insurance eob or in accordance with insurance information on file.

221 group number is invalid for washington medicaid.

222 claim has partial or multiple primary care options plans/types. Please bill each month of service
individually, and bill the appropriate hmo/ mhc plan or DSHS, as noted on the client's medical id card.

223 the approval code is invalid.

224 the backup documents/comments were not received. Please rebill with the appropriate information.

225 re-admit within 7 days lacks information. Form letter will follow.

226 this claim cannot be processed as submitted. Please resubmit on a ub-92

227 claim charge is out of balance/invalid. If insurance pd rebill w/money in amount pd field, attach the eob.
If Medicare pd rebill on appropriate form. Credits/DSHS payments can't be processed. Exclude tax from
charge.

228 invalid ita indicator. Please refer to your billing instructions for valid indicators

229 the maximum amount has been paid for this service by the managed health care program. Therefore, no
payment is due from this department.

230 there are missing/incorrect/unsubstantiated units, days or time not indicated. Please refer to appropriate
billing instructions for the date of service billed.

231 these services are not covered on the "emergency medical only" program. Home health services require
prior authorization.

232 medical records for drg's 468, 476, and 477 are required. Please resubmit with required information.
233 missing or invalid admission date. Please correct and resubmit.
234 the department cannot accept altered or retouched backup (medical id cards, award letters, eombs, etc.)
Please obtain original documents and resubmit. Eligibility unit, nh, loc 55, general, 996
235 modifier necessary to process this service is missing. See your billing instructions.
236 if authorization is needed, or services billed are not in accord with auth given, before submitting an
adjustment please call 1-800-634-1398. For dme/prosthetics/orthotics call 1-800-292-8064.
237 if authorization needed, or services billed are not in accord with authorization given, please call 1-800-
634-1398(inpatient hosp/mri auth) 360-586-5299(respiratory program)dme & all else see billing
instructions 331,349,353,602,603,604,605,606,607,608,60
238 readmit denied. Resubmit with complete medical records for all related admits.
239 hospital claim requires authorization - medical records will be required for review. Please resubmit with
complete documentation.
240 the tooth number/arch/quadrant is not appropriate for the procedure bill ed. Please see your billing
instructions.
241 swing bed charges must be billed as an inpatient claim type.
242 services not authorized. For hospital admits call 1-360-725-1584, or for dme/prosthetic/orthotics call 1-
800-292-8064, all others please refer to appropriate billing instructions under "important contacts".
243 therapeutic apheresis includes payment for evaluation and management services.
244 authorization number for these services assigned to another provider.
245 service date not covered on prior auth #. Call: hospital admits 1-360-725-1584; pharmacy 1-800-848-
2842; dme/prosthetics/orthotics 1-800-292-8064; all others please refer to billing instructions.
246 Additional units are not authorized. For dme/prosthetics/orthotics call 1-800-292-8064, for home health
call 1-800-545-5392, or for hospital admits call 1-360-725-1584. All others please see billing
instructions.
247 the dollars billed exceed the prior authorization limits. For dme/ prosthetic/orthotics call 1-800-292-
8064. For dental services see your billing instructions.
248 the procedure code/type of service/modifier is incorrect, missing, illegible or non payable for this date of
service. Please refer to your billing instructions valid for your date of service.
249 the diagnosis indicates routine newborn care which should be billed under newborn codes. Please refer
to your fee schedule.
250 only one d1330 allowed per year and one 4112d allowed per year. Second oral hygiene instruction at 6
month recall must be billed under code 4112d.
251 services billed do not match services authorized. For hospital admits/ /mri/short stay; 360-725-1584
pharmacy; 800-292-8064 dme/prosthetics/
253 the--from--date of service is past the--to--date of service.
254 these services are denied in accord with hmo/mhc denial. Any discrepancies contact the hmo/mhc
carrier.
255 max allowance of 2 postoperative epidurals for pain management has been met.
256 modifier 90 on your claim indicates you are billing for the referenced lab. You must enter the referenced
lab provider number in the performing provider number field. (box 33, pin) 174
258 Alcohol/drug detox claim exceeds program limits.
259 the first date of service is not the same as the admit date and this claim does not meet interim outlier
criteria.
260 the admission hour is missing or invalid.
261 the discharge hour is missing or invalid.

length of stay is 24 hours or less. Please rebill as an outpatient claim.

neonatal claims must indicate the baby's birth weight in grams and must be greater than 100 grams. Please correct and resubmit.

this claim was priced as an interim outlier.

After department review, your adjustment request was processed as a regular claim.

drg claims must include all dates of service (including ineligible days) and charges. Refer to your billing instructions.

this claim appears to be an interim outlier but the admission date does not match the original claim.

part b charges need to be billed to Medicare. Resubmit the drg claim attaching the Medicare eomb.

one client per claim. If services are for baby on parents pic, use b indicator in appropriate field. If multiple births, indicate twin a or b or triplett a,b,or c. Please refer to your billing instructions. Info/deny - not tied to any exception.

payment for psychotherapy and psychiatric related hospital calls is limited to one (1) call per patient per day, regardless of provider.

class 24 and claim does not indicate amount paid by Medicare 193

only one physical therapy/occupational therapy/speech therapy/ nutritional therapy assessment or evaluation is allowed per year.

edc/delivery date was not indicated on your claim. Services billed are beyond the billing limitation time period.

the primary diagnosis or procedure code does not normally require inpatient hospitalization. Please bill outpatient or call qffs at 1-800-634-1398. Qffs

claim indicates involuntary (ita) services but the diagnosis is not psychiatric.

this service is not payable for clients who are eligible for the qualified Medicare beneficiaries (QMB) program only.

same or similar services paid to another provider or performing provider number for same date of service.

the backup documents/comments are inappropriate, lacking information, or are not in the correct field. Please rebill with the appropriate information.

these procedure codes are only valid for clients on the gau or w program refer to your dental billing instructions for appropriate procedure codes.

when submitting claim for processing, all claim/backup info must be legible. Print must be dark & font size readable. Printer must be properly aligned. Do not use highlighters or red ink.

your assigned authorization number must be used when billing for the approved services. You are also responsible to notify other providers of the auth number when their services fall under the same approval. Mas

under certain circumstances 2 or more modifiers may be necessary. In such situations mod 99 should be added to the basic procedure. Also list other mods in appropriate area on claim or in remarks section. Info, and 222

due to a payment received by DSHS from an insurance settlement or payment no further payment is due. The client is not responsible for any balance. If you have questions please call 1-800-562-6136. TPL trauma info

the eob received was from an incorrect insurance carrier. Please rebill with correct eob. If you have any questions please call 1-800-562-6136.

more than one insurance carrier is available. Please submit eob backup for each carrier. Any questions call 1-800-562-6136.

After maa review this drg 468, 476, or 477 is being paid at the ratio of costs to charges (rcc) rate.

290 charges in excess of co-pay amount, or procedure code is not appropriate for co-pay billing. Please refer
to your billing instructions. Tpl

291 this has been verified with the insurance company and the eob denial submitted was in error (by
insurance carrier). Please rebill the insurance carrier for a corrected eob.

292 please remove all Medicare part b charges from your claim or resubmit with a Medicare part b denial.
293 denied lines may be submitted on original claim instead of an adjustment. Delete paid lines and correct
totals. Claims must be readable & remittance advice must be attached to show timeliness.

295 each date of service for continuous home care must be billed on a separate line. The dates of service
must be itemized on the ub-92 claim form or in the remarks/comments area of the electronic claim.

296 each date of service for inpatient respite care must be itemized on the claim form. A maximum of 5
consecutive days can be billed at one time. Please refer to the hospice billing instructions.

297 please bill Medicare. Hospice care, including professional fees, is covered in full by Medicare part a.
298 hospice professional fees must be billed as Medicare part b charges when client does not have Medicare
part a coverage.

299 hospice services are only available to medicaid clients who are eligible for the title xix categorically
needy program (cnp) and for clients eligible for medically needy program(mnp).

300 this claim was forwarded to mental health.

301 if this is a 3 day alcohol detox or a 5 day drug detox, please refer to your billing instructions.

302 this is an incorrect procedure code for this date of service. Please see your billing instructions/fee
schedule or cpt.

303 this service is included in the flat fee for delivery or trimester care.

304 gau or w program client - please refer to your dental billing instructions emergency medical/dental state
only programs section for covered services and codes.

305 the dates of service do not equal the number of days/units billed. Be sure your dates of service are
entered in the correct fields and bill only consecutive dates on one line. Please correct and resubmit.

306 this service is not payable. It does not meet the federal requirements for sterilizations.

307 this claim is being referred to the provider relations unit. For information call 1-800-562-6188.

308 the maximum of one supplemental per delivery has already been met.

309 exceeds limit. Anything in excess of limit requires approval. Please see billing instructions for more
information. If any questions, call provider relations at (800) 562-6188.

310 this is a managed healthcare fqhc/rhc premium enhancement for procedure code 0357m. Mccm gross
adjustment

311 exceeds maximum limit of 2 per client, per month. Please see billing instructions for date of service
billed. If additional amount needed please call for an extension to limitation - see billing instructions.
Info

312 hospice care restricted to client's designated hospice agency and primary physicians. Resubmit claim
with documentation to confirm these services are not related to the client's terminal illness.

313 client has elected to receive hospice care. These services are included in the hospice reimbursement and
should be provided by the designated hospice provider. If questions call 1-800-562-6188.

314 Anesthesia services are not appropriate/rbrvs indicates no base or time units for this procedure on this
date of service.

315 treatment of this diagnosis must be approved by the regional mental health administrator.

316 this provider number and procedure code are not compatible.

317 these services are not payable to emergency physicians.

318 the provider of the service should be billing.

319 stat charges are not allowed with the lab/procedures billed.

320 these services are payable only to a birthing facility licensed by DSHS.
321 service(s) not payable for a client who is 21 years of age or older.
323 this service requires medical consultant/dental consultant/nursing care consultant approval.
324 this service/fee for service is included in the global fee or major procedure.
325 these services/procedure/diagnosis are not provided on the medicaid program. Please see your billing instructions.
326 the cost of vaccines are no longer covered. Maa will continue to reimburse for the administration only. Bill the vaccine with modifier 1h/sl 577
327 services are not payable-consent form is improper/incomplete or missing. A valid, properly completed consent form is necessary to process each sterilization/hysterectomy claim. Obtain consent form from surgeon.
328 this provider number is incorrect for the claim form or procedure code billed. If a different type of provider number is needed, please call 1-866-545-0544.
329 doh office of children with special healthcare needs approval stamp and/or case coordinator name/initials - missing/invalid.
330 your claim has been forwarded to developmental disabilities.
331 circumcision is not covered for this condition.
332 Approval must be obtained from the medical consultant.
333 this claim/detail line has been reviewed and will appear on ra under a new claim number.
334 these services are denied in accord with Medicare/managed Medicare plan denial.
335 please rebill as a crossover on appropriate claim form per your billing instr. If billing a hcfa 1500 please add an "xo" in box 19 to indicate a crossover claim. Include Medicare ra with billing.
336 Medicare denied lab procedures billed with a routine diagnosis. If a non routine diagnosis is available, resubmit to Medicare. Do not rebill medicaid without further Medicare processing.
337 this diagnosis code is not recognized as a condition for high risk trimester care management or high risk delivery.
338 According to state office records this client is not on the correct program for this procedure code. If 0367m or 0368m the client has to be on "s" program.
339 this exceeds program limitations.
340 this procedure/revenue code or ndc does not match the description of service. Please correct and resubmit.
341 the diagnosis for this procedure does not indicate medical need.
342 routine nail/foot care is not covered on the program.
343 these services are not payable to a psychologist.
344 this is included in fee for the radiology procedure.
345 these services are not payable to a radiologist.
346 only approved centers of excellence can bill sleep study icd-9-cm procedure code 89.17 or 89.18. When billing these codes you must also bill with diagnoses code 780.
347 An encounter fee procedure code must be billed as all services are included in the allowance for the encounter. Rebill if necessary, using the correct code.
348 Additional written justification is required for this service or the service is inpatient hospital. Any questions, please call tim roth at (360) 725-1316.
349 evaluation and management procedure not allowed with osteopathic treatment.
350 this service is not routinely covered except by special agreement. For criteria/application information call (360) 725-1136 or 1-800-562-6188.

351 dental related services not routinely covered outside dentists regular working hours. Please state if the
office call (not consult) was for a physical exam prior to dental surgery or dental related hospital stay.
352 this service/diagnosis is not covered under the program except under epsdt/healthy kids screening.
353 only one prenatal lab is allowed in a nine month span. The fee reduced accordingly.
354 our records show this is an established patient, the procedure was changed accordingly.
356 initial 60 day enrollment period has been exhausted. Please contact provider relations at 1-800-562-
6188.
358 the procedure/revenue code was changed per medical policy guidelines.
359 the procedure code/modifier was changed/added to match the description of service or modifier removed
to facilitate processing.
360 the initial procedure was billed previously, subsequent procedure paid.
361 Any combination of table 1 lab tests/panels cannot be submitted individually. Bill as a single panel
using the code that reflects the total number of tests done. See your fee schedule/cpt for more
information.
362 you have used a performing or attending provider number that has been terminated by medicaid
authority. If you have questions please call provider enrollment at 1-866-545-0544.
363 labor management is allowed only to the physician that has managed prenatal care but does not perform
delivery due to complications.
364 the Medicare statement date is missing. A copy of Medicare's remittance advice (ra) or explanation of
Medicare benefits (eomb) is required. The ra/eomb must include the Medicare statement date.
365 these procedure code(s)/rev codes not allowed in combination with other procedure codes/rev codes.
Please see your billing instructions.
366 A second assistant at surgery, co-surgery or team surgery is not allowed.
367 this provider number is for identification use only. Please do not use as a--pay to--number.
368 this is an incorrect provider number for the claim date(s) of service.
369 your rebill is not timely. Rebilling requires you to submit a claim with an ra attached or a reference to
the original claim number. 125. This eob combined into 018,10/25/00.
370 services do not meet the medicaid home health criteria (smc)- 371, 448,
371 interpreter services rendered in a community mental health center are included in the regional support
network (rsn) payment.
372 there is no record of the appropriate license which is required for this service (see billing instructions).
This license must be filed with maa before submitting claim. Please call provider enrollment 1-866-545-
0544.
373 this claim has been adjudicated in accord with medical assistance administration (maa) medical review.
374 qrs adjustment--adjudicated per qrs review. Info
375 when billing procedure code 0351m (newborn premium) and 0357m (fqhc/rhc supplemental) for
newborn you must use the baby's patient identification code (pic).
376 the fitting fee is included in the fee for prosthetic, orthotics and ostomies.
377 please rebill with appropriate coding for medical vendor claim type(p), attaching Medicare eomb denial.
378 claim cannot be processed without properly signed & completed ita patient claim information form
(DSHS 13-628). Please attach completed form & resubmit claim. Contact your county ita designee for
assistance.
380 maximum dollars allowed for number of automated lab tests (internal code) has been met or is being
paid on this claim.
381 this claim appears to be a fair hearing or exception to policy, it will be processed on a new icn.
Information only - all units

382 rebill attaching the retroactive/delayed certificate with date on the coupon.
383 this is an adjusted fee after medical consultant/nurse consultant review of your claim.
384 this is not in accord with medical/dental policy guidelines/regulations.
385 your plan of care was received, however updated m.d. orders/clinical notes are needed to justify treatment.
386 requested services/units have been paid on multiple claims.
387 your claim/line has been split to facilitate processing.
388 emergent need not shown for these services
389 services for this diagnosis are not provided on the medicaid program.
390 this adjustment reflects an maa settlement action. Mrs
391 please refer to your fee schedule and/or billing instructions for correct billing procedure and/or limits.
392 Additional justification needed for this service per quality services section. Qrs
393 the procedure code was modified in accordance with the written description of records reviewed by the quality review services. Qrs
394 number of calls for this diagnosis has been reduced after surveillance and utilization review. Mrs
395 this service is not provided under the medicaid program. Mrs, 094, 756
396 level of care reduced after review of information provided to the quality review services section. Qrs
397 your adjustment request has been reviewed, the original disposition was correct. Info for adjustments
398 the dates of service and/or charges were adjusted to match the eligibility data available to this office.
399 According to our records the performing provider number for the date of service on your claim does not match the provider the client has chosen through enrollment.
400 this ndc requires authorization. Please call pharmacy authorization at 1-800-848-2842.
401 one prenatal assessment/labor management allowed per pregnancy.
402 this prescription was denied and subsequently paid on the same remittance and status report. Info pos.
403 the prescription "written" date is missing/invalid.
405 the ndc is missing.
406 the ndc is invalid.
407 services approved under multiple authorization numbers must be billed on separate claims and/or the correct authorization number must be billed on claim for services submitted.
408 the prescription number is missing.
409 the prescription quantity is missing or invalid.
410 the expedited authorization number on this claim is missing, invalid or not valid for the ndc billed. Please refer to the prescription drug program billing instructions.
415 our records do not indicate you have fulfilled the necessary professional training requirements required by law to perform these services.
416 maximum units allowed for epidural anesthesia.
417 bill only one date of service per line info
418 gau/medically indigent/w program client - approval is required for these services. Refer to your billing instructions.
419 this is a narcotic - no refills are allowed.
420 this is a corrected payment to a unit dose dispensing fee credit
421 this is a credit to a previously paid prescription. Info pos
422 multiple mileage codes not allowed when transporting more than one client to the same destination.

425 this is the 3rd prescription in a calendar month. See limitations in the prescription drug program billing
instructions.

426 avialable

427 partials replaced within a 5 year period require justification. See the dental program billing instructions.

428 this claim or detail line has been reimbursed under the trauma program. System generated info.

429 the performing provider number on the claim is not listed as a certified medical interpreter or is not
listed as the performing provider for this date of service. Any questions please call (360) 725-1316.

430 this claim has been reprocessed because of eligibility problems with the states eligibility database dating
back to 4/6/96. If you feel that additional claims qualify as eligible, you may resubmit them directly.
Mass adjustment released 8/4/97.

431 multiple units are inappropriate for this procedure.

432 provider enrollment has not received the necessary documentation from the provider to allow this
service. Call 1-866-545-0544.

433 please forward your claim to developemental disabilities 432

434 multiple root planings/extractions/restorations must be billed on separate lines with all required
information per your billing instructions.

435 diagnosis requires auth. Enter the auth # in correct field. For approval

436 drug name, quantity dispensed/units & or strength is not indicated on your claim. Please resubmit with
the appropriate information.

437 this was denied by Medicare. If this is a DSHS covered service and the medical id card does not
indicated "QMB-Medicare only", please rebill on the appropriate claim form attaching the Medicare
denial.

438 inpatient services related to a hospital admit (99221-99223) that requires approval are not payable until
the approval for the admit is obtained.

439 diagnostic work-up and treatment (like surgery) are considered one admission. Denial eob used by ncc's
for exception 218

440 claim reviewed and client is not enrolled for these dates/service(s).

441 According to state office records this client is not eligible. If you have any questions please call (360)
725-1894. Sur for 229 project

443 neonatal jaundice is part of drg 391, 620, or 629 - normal newborn.

444 this is a corrected payment to a previously paid prescription (used for amac mass adjustment 08/97)
(used for regular mass adj)

445 this is the federally qualified health center's month end adjustment. If you have questions please call
(360) 725-1840. Info eob for oamr - fqhc

447 the nursing facilities name and/or provider number is invalid or missing. Please correct and resubmit.

449 modifier 1h/sl is not valid for this procedure code.

450 A federally qualified health center encounter procedure code is not allowed for this service. Removed
from text 3/4/03

451 this procedure code requires a valid tooth number, arch or quadrant. Please see your billing instructions.

452 please note: units or quantity are incorrect or excessive for the services billed. Review billing
instructions for correct quantity to be billed. If any questions, please call provider relations (800) 562-
6188.

453 single x-rays and bitewings are included in intraoral - complete series (00210/d0120).

454 only 1 panorex or full mouth series allowed every 3 years.

455 the professional or technical only portions will not be paid in addition to the global procedure.

456 sleep studies are limited to maa approved centers of excellence and to certain icd-9-cm diagnosis and
procedure codes. Please refer to your billing instructions. For questions call 1-800-562-6188.

457 the maximum sealant allowance has already been met.

458 this procedure code is only allowed for take charge clients - this client is not on the take charge program.

459 invoice does not match description of service.

461 trimester care/high risk trimester add-on care has been paid in part or in full.

462 paid in accordance with insurance eob. Charges to deductible.

463 paid in accordance with insurance eob; coverage terminated/date of service during lapse in
coverage/service prior to insurance coverage.

464 paid in accordance with insurance eob. Non-covered service.

465 paid in accordance with insurance eob. Benefits exhausted.

466 paid in accordance with insurance eob. Waiting period not met.

467 paid in accordance with insurance eob. Pre-existing condition.

468 the allowance of 12 chiropractic calls per twelve month period has been met.

469 the maximum allowance of 12 hours a day community mental health stabilization services has been met.

470 the maximum allowance of 6 hours a day of adult day treatment or child & adolescent day treatment has
been met.

471 the maximum allowance of 6 hours a day of community mental health diversion services has been met.

472 fee for service claims are not covered. They are included in your capitated rate. Questions contact 1-800-
562-6188.

473 high risk delivery add-on fees should only be billed by the delivering physician.

474 the accident date is invalid.

475 the procedure code is missing. If dental claim and procedure code was billed with 6 digits, it is invalid.

477 the admitting diagnosis code is missing or invalid.

478 client is not eligible for all dates of service. Please delete ineligible dates and rebill.

479 only one extraction is allowed per tooth. Only one root canal is allowed per tooth.

481 only one service covered for every six month period.

482 to avoid delay in payment, do not put Medicare's deductible and/or coinsurance in box 32 on hcfa 1500
claim form. Please refer to your Medicare part b/medicaid crossover billing instruction.

484 According to our records, this client is a special low income Medicare beneficiary. In order to receive
fee for service for baby, please rebill with the baby's patient identification code (PIC).

485 insurance info is listed on your DSHS claim form. Do not enter Medicare, medicaid or healthy options
as insurance. Please rebill with private insurance eob. If questions call 1-800-562-6136.

486 our records indicate patient was hospitalized during this time period.

487 review of the claim and the attached eob has resulted in denial. The patient, date of service or other
fields on the claim do not match those on the attached insurance eob. If questions call 1-800-562-6136.

488 maximum allowable for bitewings has been paid.

489 this client is eligible for family planning services only. If services are for a baby, rebill with the baby's
patient identification code (PIC) 525

490 in order to process this claim, a copy of Medicare's remittance notice or explanation of Medicare
benefits (eomb) is required. The remittance/ eomb must include the Medicare statement date.

492 A current award letter is required to reduce patient participation and/or update eligibility. Used for
nursing homes

494 please remove diagnosis and charges not related to detoxification and resubmit claim. Refer to your
detox billing instructions.

495 Admit diagnosis does not indicate detoxification. Please refer to your detox billing instructions.
496 diagnosis is not valid for detox claims - refer to your detox billing instructions.
498 the maximum allowance of one premium payment per month has been met.
499 this drug is from a non-contract manufacturer and not payable.
500 provider previously refunded to department of social and health services cash control
501 repeat norplant capsule removal paid at 50%.
502 the claim was adjusted for dates patient was eligible.
503 drg readmit payment recouped per maa.
504 the payment for this service is included in the drg reimbursement and was paid to the admitting hospital.
505 the maximum allowance of one norplant implant in five years has been met.
506 After telephone confirmation, information on this claim or line item has been corrected to facilitate processing.
507 only one drg payment is allowed for multiple false labor admissions occurring on the same date.
508 please rebill on pharmacy statement 525-106, or on the point-of-sale system.
509 the diagnosis does not indicate contraception/family planning. Procedure code j1055 is to be used for depo-provera for contraception/family
510 provider # was missing/incorrect and was added or corrected. To expedite processing please verify that your correct provider # is in the appropriate box on your claim form. For assistance call 1-800-562-6188.
511 the maximum of 20 maternity support services per pregnancy has been met.
512 the daily room rate times the number of days does not equal the billed amount.
513 orthodontic each additional three month code should not be billed until nine months after the banding for full treatment, or six months after the initial placement of appliance on limited transitional trmt.
515 services provided within 24 hours of an inpatient admission must be billed on the inpatient claim.
516 verification with the insurance company has resulted in a determination that this claim contained a billing or processing error. Please contact the insurance company for billing questions or new billing procedures.
517 reversal of expedited payment previously made. If you have questions, call toll free 1-800-562-6136.
519 this is the 5th prescription in a calendar month. See limitations in the prescription drug program billing instructions.
520 review of this claim has determined that it does not meet outlier criteria.
522 rebill on a hcfa 1500 attaching a report to substantiate the fee for the services billed.
523 this procedure code requires a valid code indicating the tooth surface. The surface must be m,o,d,b,l,i or f. For restorations the number of surfaces must match the description in the procedure code.
524 procedure code changed to facilitate payment. For future billings please refer to your billing instructions for correct procedure code when billing for second/return trips.
526 this readmit was previously reviewed by maa. The original disposition was correct.
527 the performing/prescribing/attending provider number belongs to a group. Please use the individually assigned id number.
528 the performing provider number indicated is not compatible with the billing provider number. For information call 1-866-545-0544.
530 the referring provider number belongs to a group. The individually assigned id number must be used.
531 the maximum of one monthly case management service has already been met.
532 the maximum of 1 follow-up case management service every 3 months has already been met.

533 the physician's name in the "consent to sterilization" is not the same as the physician's name in the
"physician's statement" area on the DSHS 13-364x consent form. Resubmit attaching modified & initial
consent.

534 please use modifier "1c" when billing office call procedure codes, 99201-99205 or 99211-99215 for
baby on parents PIC.

535 the remittance advice report/backup doesn't match the service/fee/date of service you billed.

536 this is a refund for a payment that was previously recouped because of third party insurance. Tpl
adjustments

537 this is a refund because payment was received from the insurance company. Tpl adjustment

538 multiple services must be billed on separate lines identifying services performed. Rebill if payment not
on your final remittance advice.

539 your claim is being recouped due to non-compliance with department of social and health services third
party liability requirements. If you have questions, please call 1-800-562-6136. Tpl

540 the primary diagnosis code on the claim is not psychiatric. The claim cannot be processed as a
psychiatric admission.

541 this claim has been paid because there was no indication on the medical i.d. card of the health
maintenance organization's coverage for the dates of service.

542 payment included in total time for major anesthesia procedure.

543 only one quadrant can be billed per line on claim. Dental

544 your claim or line item has been processed accordingly after telephone confirmation. Is not a dup of 506
(res)

545 your claim doesn't state the name of the hospital where the service was performed or the hospital is not
an approved maa center of excellence (coe) for this service.

546 this claim or service is not payable because it was not received within six months of the Medicare
remittance notice or explanation of Medicare benefits (eomb) or rebill/claim reference icn does not
verify timeliness 261,192

547 this lab procedure is included in the prenatal panel.

548 refund is being repaid because this has been recouped by medical assistance administration (maa). Cash
control

550 recoupment as requested by office of financial recovery (ofr) due to civil fine. Cash control

551 review of the claim and attached eob has resulted in denial. The claims billed amount, insurance paid
amount or other dollar amounts do not match those on the attached insurance eob. If questions call 1-
800-562-6136.

552 priced per invoice. Info

554 this procedure code requires a valid tooth number or letter.

555 this procedure code requires a valid arch designation.

556 this procedure code requires a valid quadrant designation.

557 the insurance payment that is indicated on your claim does not match the payment field on your
insurance eob. Please rebill with the correct amount. If you have questions call 1-800-562-6136.

560 this interpreter has not been authorized to bill for sign language procedure codes 9996m or 9997m.

561 maximum payment has been met for multiple endoscoPIC procedures.

562 claim/comments/report/history indicate a specific modifier is necessary and it was not used. Please rebill
with appropriate modifier in the designated field.

564 this client is eligible for family planning services only.

565 please rebill on ub-92, attaching dated Medicare part a or hospital part b (see contract adjust column)
remittance advice or explanation of Medicare benefits (eomb). Backup is not appropriate for hcfa 1500
claims 261,856,596,

566 the sixth diagnosis code is invalid. Please correct and resubmit.

567 the seventh diagnosis code is invalid. Please correct this resubmit.

568 the eighth or ninth diagnosis code is invalid. Please correct and resubmit.

569 this is a refund for a payment made by the provider or a recoupment that was previously recovered by
the payment integrity program (pip). Info

570 paid in accordance with wac 388-501-0200. Claim may be reprocessed if future information is received.
Tpl

571 the appropriate modifier has been added to your claim to facilitate the processing of your claim.

572 rebill w/appropriate backup indicating on claim/comments if private insurance or hmo/mhc. Do not put
hmo/mhc \$ in private insurance field on claim.

573 please complete, sign and date the eligibility information in section ii of the DSHS form # 13-628, ita
patient claim information and resubmit.

574 ita eligibility restrictions permits payment for three (3) days only. Please adjust days and resubmit.

575 procedure codes 90782/90788 are considered the administration of the injection which is included in the
evaluation and management procedure code. If billing for the drug itself, use the appropriate "j" code.

576 modifiers 54,55 and 56 are to be used only with surgery procedure codes. Do not use with evaluation
and management procedure codes.

577 if you are resubmitting your claim, please attach all backup necessary to process your claim.

578 length of stay cannot be determined on principle diagnosis. Diagnosis code must be billed at the highest
level of specificity as defined in the current icd-9-cm.

580 billing 2 earmolds for the same client, you must indicate right (rt) or

581 According to our records, the place of service indicated is incorrect. Info/res

582 this procedure/service is allowed once in a lifetime. If ita two evaluations have already been paid for this
detention.

583 review of this claim has determined that it does not meet medical necessity for inpatient hospitalization.
Rebill as an outpatient and be sure to include the adjusted icn and state "rebilling as op per qrs". Qrs
recoupments for 25-47 hour hospital stays

584 lab component included in the complete blood count.

585 bill initial services to crime victims compensation program, p.o. box 44520, olympia, washington
98504-4520. Followup services billed to maa must be billed with specific medical diagnosis other than
v71.5. Tpl-998, 639

586 please bill these services to department of labor and industries, p.o. box 44269, olympia, washington
98504-4269. Tpl - 998

587 pre, intra or post operative care has already been paid.

589 processed according to comments, backup, claim information or our records. Info/resolutions

590 one allowed in five years 750

591 visits billed exceed treatment plan; submit documentation to ncc and rebill.

592 there is no (current) treatment plan on file; please submit a treatment plan to the nurse consultant and
rebill.

593 this service was denied in accordance with doh children with special health care needs (cshcn) case
coordinator review.

594 sealants are covered for occlusal surface of tooth # 2,3,14,15,18,19,

595 our records indicate two outpatient admissions on same day. Please indicate the hour of care for both
admissions.

596 this claim has been denied for other reasons in addition to insurance. The insurance payment exceeds the
DSHS allowable fee therefore, no further payment is due from this department.

598 your premium payment has been adjusted as there is dual coverage under the managed health care plan.
599 According to our records this client is enrolled in a different managed healthcare plan for this date of
service. Therefore, this premium is not payable.

700 this modifier is invalid.

701 continuous passive motion system (0935e) allowed maximum of 10 days without approval. Please see
your billing instructions.

702 Assistant/co surgery/ team is not allowed for this procedure.

703 the healthy kids/epsdt indicator is not present or is invalid.

706 this client is enrolled in a primary care case management (pccm) plan. The appropriate referral # for date
of service billed must be in the correct field on claim form.

707 there is a healthy kids/epsdt referral indicator and/or diagnosis code error. Please refer to your billing
instructions.

708 this premium payment has been recouped because the client is pregnant and her obstetrician is not a
participating provider with this plan.

709 invalid client age to diagnosis.

710 invalid client sex to diagnosis.

711 this provider number is invalid for this service or procedure code.

712 the provider's specialty on this provider number is invalid for this service or procedure code.

713 this procedure is only valid for the ita program.

714 encounter codes can only be billed in conjunction with qualifying fee for service procedure codes. If the
encounter code was previously billed with fee for service codes, resubmit on adjustment form 525-109.

715 this procedure code is for the healthy kids/epsdt program. Check box 24h and use the referral indicators
when appropriate.

716 home health services for clients under age 7 and/or on the mi program require prior approval. Use
assigned authorization number or call 1-800-545-5392. No longer used for exception 448

717 these services exceed the number of home health visits/disciplines/ dates authorized. For information
about billing call 1-800-562-6188, for questions about policy call (360) 725-1579.

718 this service requires prior authorization, please enter authorization number in the appropriate section. If
approval is needed call 1-800-545-5392. Out-of-state or olympia call (360) 725-1582.

719 the fourth surgical procedure code is invalid. Please correct and resubmit.

720 our records do not indicate that this client is enrolled in the exceptional care therapy program for this
date(s) of service. Please rebill with appropriate documentation.

721 the document/form that was submitted with your claim does not establish eligibility. Please resubmit
your claim attaching an award letter.

724 this premium payment has been recouped as provider is not participating with this plan. Mhc adj

726 this premium payment has been recouped as client is homeless or in temporary shelter. Mhc adj

727 delivery and newborn care can not be billed on the same claim form. Please rebill on separate claim
forms.

728 client has elected hospice care. If these charges are for the professional component, please resubmit
with modifier 26. Otherwise contact the hospice agency for reimbursement.

730 detox can not be billed as an outpatient claim.

731 to receive the hospice benefit, the client must meet eligibility criteria and qffs must be notified within 5
working days. For questions call 1-800-545-5392.

732 this ndc has been terminated, or obsolete for more than 2 years.

733 tax obligation to department of revenue infor only for mdsh recoupments

736 the authorization number on this claim is not valid for medical necessity authorization.

737 date(s) of service are not within the hospice eligibility dates. Please adjust claim and rebill.

738 the fifth surgical procedure code is invalid. Please correct and resubmit.

739 mental health encounter code should be billed with psychotherapy service s.

740 prenatal vitamins covered for pregnant women only 519

741 the sixth surgical procedure code is invalid. Please correct and resubmit.

742 this premium payment or adjustment is not payable because the client resides out of the service area for
this managed health care plan for these dates of service. Mhc adj

743 this premium payment has been recouped due to an exemption request. Mhc adj

744 this revenue code is invalid for high risk obstetrical nursing care visits. Please refer to your billing
instructions.

745 only 3 home health visits allowed per pregnancy.

746 Medicare and/or medicaid part b payment included in the drg per medical assistance news bulletin 6/93
#2. Any questions, call (360) 725-1228, medical review section. Drg recoupment project - mrs

747 claims for babies using a parent's pic must have a "j0" in the occurrence code field and the baby's birth
date in the occurrence code date field. Please correct and resubmit.

748 baby billed on parent's/baby's pic - baby's date of birth must match date of admit. Please correct and
resubmit.

749 service is identified as being provided by a skilled nursing facility (snf) or swing bed. Please resubmit
on the nursing home turnaround document (tad). Questions contact provider relations at 1-800-562-
6188. Per 991 text

751 medically indigent disproportionate share hospital (midsh) payment. Midsh gross adjustments

752 low income disproportionate share hospital (lidsh) payment lidsh gross adjustments

753 medicaid disproportionate share hospital (mdsh) payment. Mdsh gross adjustments

754 pas extension request has been denied per medical review. Please adjust dates of service, charges and
resubmit.

755 the approved pas length of stay extension does not cover all the dates of service and/or days billed.
Please adjust days billed or resubmit with approval for all dates of service. Pas begins on date of admit.

756 services are not in compliance with the chemically-using pregnant (cup) women billing requirements.
Please refer to your billing instructions.

757 the service requested is being denied per policy guidelines.

758 unable to process - billing number missing/invalid 121,416

759 your individual mi disproportionate share hospital payment reflects a 3% reduction which was mandated
on december 1, 1991 due to budgetary shortfalls. System generated on hospital claims for mi clients

760 program max allowable has been met. Services exceeding the max allowable require authorization. Call:
(360)407-0303 or 1-800-422-3263(aasa nurse advisor) 013,094,755

761 evaluation/management procedure codes are not appropriate for eye examinations for visual acuity.

762 payment for these services are not allowed with this diagnosis.

764 evaluation/management procedure codes & eye examinations are not allowed in combination.

767 when rebilling please attach dated Medicare remittance notice or dated eomb.

768 client is on family planning only program or take charge program. Remove all charges and diagnosis not related to family planning services and rebill.

770 clia number not on file.

771 clia number on our file does not cover this date of service.

772 clia certificate covers waiver or physician performed microscopy procedures (ppmp) only.

775 insurance plan not a recognized capitated plan. If you have questions, please call 1-800-562-6136. Tpl

776 this claim is paid in accordance with verified capitated plan. Tpl

777 this is rural health center's finalized cost settlement. If you have questions, please call (360) 725-1840. For doss

778 clients on the take charge program may only receive services from a take charge provider, or an ancillary provider performing family planning related services referred by a take charge provider. See memo 01-53.

779 our records/billing diagnosis indicate there was a multiple birth. Please rebill if appropriate, identifying twin a,b or triplett a,b,c or correct diagnosis if single birth.

780 respiratory therapy initial home visit allowed one time per provider per client.

781 procedure code changed to match authorized services. Please use on future billings. If orthodontic authorization questions call 360-725-1592. Dental auth

783 we are unable to process this claim as the eob does not contain the printed denial reason from Medicare/insurance/managed health care plan.

784 the insurance payment was not transferred from backup to the appropriate field on your DSHS claim form. Please correct and resubmit. If questions please call 1-800-562-6136.

786 per the special agreement with your hospice agency, when billing for a client in the hospice care center, you may only bill revenue code 651, or revenue code 652 in combination with revenue code 650.

787 this claim is being recouped as not meeting the specified criteria listed for the exped. Prior auth. Billed or you did not submit records as requested. If questions, call qus at 1-800-292-8064. Mrs (qus)

788 this revenue code is invalid for home health services. Please refer to your billing instructions.

789 services included in critical care/neonatal intensive care

790 An original claim in paid status for these dates of service is required before additional and/or late charges can be processed.

791 multiple providers billing for the same dates of service.

792 According to state office records this client is enrolled in the special low-income Medicare beneficiary program and no medical services are covered under this program.

795 the procedure code does not match services authorized. Please rebill with the medical assistance administrations orthodontic information sheet to substantiate services billed.

796 this client is covered by managed healthcare 248,251,254,258,270,507,508,526-530,538-541,545,546,550,552,490

797 medical encounter code (9000m) is required for an evaluation and management (e&m) (99202-99205,99212-99215) billed on same day. (must be billed on same claim).

798 these services appear to be for late charges. All charges for a drg admit are included in the drg payment. Late and/or additional charges are paid separately only when there is a paid drg outlier claim.

799 procedure code 64450 is inappropriate with minor surgical procedures which only require a local anesthesia. Locals are included in the surgical procedure.

800 this procedure is considered a bundled service and is all inclusive.

801 your special agreement requires a description for each procedure code and/or the actual time for the "use of faciltiy or recovery room." 331,362

802 the claim has money entered in the paid field, rebill indicating source of payment. If from insurance, attach eob. Do not enter Medicare co-ins/ deductible or DSHS payments as third party payments. Tpr 1-800-562-6136.

803 Anesthesia services have already been paid in part or in full.

804 this is a duplicate of claim or service previously paid. Any questions contact medical review section at (360) 725-1228. Dcs/cob audrey finnigan

805 procedure has been manually priced in order for you to receive maximum payment for services performed.

809 After hours charge/emergency service/sunday or holiday charge not allowed in combination.

811 no rate has been established for this service. Please call (360) (360) 725-1847.

812 prolonged care cannot be billed alone or w/inappropriate procedure codes. Services must be billed on same claim for proper payment. An adjustment may be necessary.

813 co-pay processed for Medicare managed healthcare plan. Loc 55

815 daily rounds are included in allowance for psychotherapy.

817 these services must be billed on the ub-92 claim form. Please refer to your billing instructions.

818 only one delivery in a nine month period is allowed. Cesarean/delivery has previously been billed for this client.

819 maa's limit of 2 nursing home visits for routine medical conditions has been met. Requested limit extensions may be faxed to 360-586-1471 for review. See your physician related billing instructions.

820 the Medicare managed healthcare payment exceeds the DSHS allowable fee.

821 labor and industry payment is considered payment in full. Tpl - casualty unit

822 there were multiple operative procedures billed and modifier 5a and 5b was not used. Please see your ambulatory surgery center billing instructions.

823 multiple procedures for this date of service have been priced according to department policy.

824 this evaluation/management procedure code is billed during a surgical follow-up period. See your billing instructions.

825 procedure code is not allowed/payable in combination with another procedure code billed. Please see your billing instructions.

826 According to state office records this client is not enrolled with this fqhc or rhc. Check your appropriate healthy options billing instructions for the date of service on your claim.

827 the provider number on this claim is not valid for the procedure code billed. Please refer to your healthy options licensed health carriers billing instructions.

828 expedited authorization/limit extension is required for selected procedures and diagnosis. See applicable memorandum or billing instructions.

829 monthly gme payment cash control for gme gross adjustments

830 this is a duplicate of a paid claim that has been refunded.

831 there is \$ in the amount pd field on claim. If insurance/mhc/hmo rebill w/eob. If Medicare, bill on appropriate form w/eomb. Do not bill previous payments made by DSHS. Questions, call prr at 1-800-562-6188.

833 the date of service on the consent is missing or does not match the date of service on the claim form. Please correct and resubmit.

834 collagen/contigen implant is only covered for the diagnosis of intrinsic sphincter deficiency (isd), dx code 599.82.

835 ho/managed healthcare plan (mhcp) mhcp paid services are paid in full, therefore nothing is due from maa. Denied services may be rebilled. Delete paid lines, correct totals, and attach the mhcp ra or eob.

837 per policy guidelines the encounter is denied as there are no payable qualifying services on this claim for the same date of service.

839 this claim has been adjudicated in accord with the regional support network (rsn).

841 auto/non-automated lab, same date must be billed on same claim. No auto/ non-auto lab pd? Rebill all on 1 claim (hcfa 1500/ub-92)form. Some pd/ some denied? Adjust pd claim adding denied auto/non-auto lab services. Tied to 013

843 claims for sterilizations must be billed with a sterilization surgical procedure code and the date of surgery (ub-92 form locator 80-81). Please correct and resubmit.

844 only approved chronic pain management facilities can bill revenue code 511. Please correct and resubmit.

850 federally qualified health center encounter procedure codes are not payable for clients on state-only programs.

852 this procedure code has been manually priced according to the units you have listed on the claim.

853 unable to pay this dme item without a valid maa dme provider number. Please call provider enrollment at 1-866-545-0544.

854 this claim requires an rsn (regional support network) authorization. Please contact your rsn. Refer to memorandum #01-10.

856 delivery and/or newborn services should be billed as an inpatient claim. Please correct and resubmit.

857 refund received from provider due to healthy options or basic health plan coverage. Cash control (adj) - keep

858 this claim/line is being recouped because it's use appears to not meet department guidelines and/or regulations or you did not submit records as requested. Please review billing instructions for proper use. Info

859 these services/procedure/diagnosis are not covered or may be bundled on the medicaid program. It may be necessary to obtain approval. Please refer to your billing instructions.

860 provider number must be a dietician in one of the following fields: physician claims (billing or performing), outpatient claims (attending), medical vendor claims for nutrition (referring).

864 nursing home Medicare/medicaid crossover claim manually priced per rate information from provider/Medicare.

865 this/these item(s) included in current or previous billing. Please refer to billing instructions for proper coding. Any questions call provider inquiry at 1-800-562-6188.

866 bilateral modifier 50 and/or modifiers lt/rt not appropriate with this procedure.

868 the inpatient/outpatient non-availability statement was not received. Please contact the nearest military treatment facility.

870 An intake evaluation is not covered within 30 days of the previous drug abuse service.

871 After review of your original claim, the department has found that an adjustment is due. Please do not rebill. The department will adjust and your claim will appear under a new icn. Adj and phys res

872 this claim has been recouped due to deers eligibility being re- established. Please contact or rebill the third party insurance carrier for payment of this claim.

873 the adjusted allowed amount on this claim or detail line is more than than the original trauma enhanced payment. This claim or detail line has been paid at the new allowed amount with no trauma enhanced payment. Adj - per ren # 4162

877 effective 04/04/02, modifier 9t (trauma enhancement) has been removed from the detail line and retained in our records in order to accommodate the other pricing modifiers on your claim. Manual info claim header eob.

891 only five screens are covered during the first year of life.

892 only one annual screen is covered per year after the 2nd year of life.
893 the yearly limitation has already been met.
894 the refraction/examination allowance for patients 21 and older has been met.
895 oral anti-emetics (q0163-q0181) must be billed on the same claim form with one of the anti-neoplastics (j8530-j9999). See #memo 98-12. If (j8530-j9999) already paid, an adjustment to that claim may be necessary 590
899 our system is unable to process this claim as received. Refer to each detail line for explanation of problems or split claim & rebill. For further questions please call provider inquiry at 1-800-562-6188.
900 paid to lien holder. Sys gen
901 lien payment. For mass/gross adj keep
902 the icn to be adjusted is now being or has been adjusted. Please refer to your remittance report.
903 the code you have billed maa does not match the code billed to Medicare. Please resubmit with proper coding. Any questions call provider inquiry 1-800-562-6188.
904 the primary insurance company and Medicare's payment exceeds the DSHS allowable fee.
905 trimester/postpartum care or high risk management allowance has been met for this time period. See rbrvs billing instructions.
906 this claim cannot be adjusted as the patient id is missing or invalid.
907 An adjustment was made due to a change in the patient liability. Nursing home/hospital adjustments
908 pras adjustment - adjudicated per pras used by the audit section
909 this service is included in the visit rate.
910 multiple services/calls are not allowed on the same day.
911 one trimester care/ high risk management procedure allowed per calendar month. See # memo 96-98 for 01/01/97 date of service and after.
912 funds have already been awarded to your county auditor under the grant-in-aid program. Ita uses - keep
913 this is an adjustment to services previously paid or denied. Used on adj - keep
916 please bill Medicare or resubmit with a current Medicare denial.
917 trimester care/high risk management procedure billed out of order or in the incorrect month of antepartum. Refer to rbrvs billing instructions
918 our records indicate Medicare benefits are available. Please resubmit to Medicare/managed Medicare plan-questions regarding Medicare eligibility, contact medical review section, p.o. box 45570, olympia, wa 98504-5570.
919 our records indicate Medicare benefits are available. Please resubmit to Medicare. Any questions call (360) 725-1228, medical service review. Dcs/cob Medicare project
920 Medicare paid amount/deductible missing. Please resubmit with necessary information for processing.
921 the number of days billed has been increased or decreased.
922 the patient class for this client has been changed.
923 this is a gau client--services covered by grant in aid.
924 this service is covered by a contract provider.
925 this service is provided by the eyeglass contractor.
926 there was a retro rate change. For questions call (360) 725-1853. Cash control (rate adj) - keep
927 per cost settlement. Cash control - keep
928 there is a claim error. Cash control (adj) - keep
929 vender review audit made. Cash contrl
930 procedure code has been changed to maa replacement denture or partial denture procedure code.

931 this was paid to the wrong provider. Cash contrl - keep
932 medical services review, any questions call (360) 725-1894. Cash control - keep , dcs/cob
933 please rebill on the american dental association dental claim form
934 please rebill on hcfa 1500 with the appropriate provider number.
936 please rebill on pharmacy statement 525-106 with appropriate provider number. Used in exam enry
937 our records indicate that this service has been paid in full by Medicare/DSHS.
939 dmso, dimethyl sulfoxide (j1212) is only payable for instillation for the diagnosis of interstitial cystitis (595.1).
940 this service exceeds the ita length of stay limitations. Attach approved mental health extension or adjust days billed and resubmit.
941 the admit/service dates are prior to the detention period indicated on the ita stamp/DSHS 13-628 150,190
942 the maximum reimbursement for drug/alcohol related services has been met under the ita program.
944 our records indicate the patient has received a settlement/payment from the insurance company. Please contact the patient for payment. If you have any questions please call us at 1-800-562-6136.
947 code not compatable with med vendor claim type, see your billing instructions for proper coding for service/item being billed.
948 this service is included in your base rate. Info
950 A math error on your billing has been corrected. Do not add tax to your billing claim forms.
951 the resubmission icn or information supplied does not verify timeliness for the original claim. 125. This eob combined into 018, 10/25/00.
952 this client was not in a nursing home during the date(s) of service billed.
954 fee adjusted to maximum allowable for bitewings.
955 payment was applied to pip recovery and paid to office of financial recovery. Prov # 8900854, ofr-pip payment offsett
956 payment was applied to qrs recovery and paid to office of financial reovery. Prov # 8900892, qfr-qrs payment offset
957 All services must be billed in compliance with dental fee schedule. For questions call 1-800-562-6188.
959 ventilation management is included in the evaluation & management service.
960 this is a duplicate of Medicare tape or crossover already processed.
961 each provider/performing provider of service must bill on a separate claim form.
962 claim has been referred to the dental/orthodontic consultant. Please do not rebill, this claim is still pending. Dental info
963 pip offset payment. If you have any questions please contact financial recovery at 1-800-562-6114. Prov # 8900854, pip gross adj offset.
964 no record of recipient enrolled in your hmo/hio for this period. If medical services have been rendered bill under the fee for service
965 qrs offset payment. Prov # 8900862, qrs gross adj payment offset.
966 enter on the ub-92 claim form: field 39a-deductable, field 40a-co- insurance, field 41a-paid by Medicare, box 41d-Medicares process date (mmddy). Claim must match Medicares remittance advice/eomb. Hospital info
967 this claim cannot be processed for payment. Maa cannot verify the original disposition on claims with dates of service more than 3 years old.
968 this claim can not be processed as received.
969 this claim is being returned with a letter of explanation.

970 Action has been taken to clear credit balance report. Cash control
971 transferring "credit balance" on inactive/terminated provider number to current provider number. Cash
control
972 this fqhc is not payable based on the clients csor and/or not a valid fqhc for the date of service.
973 interest payment tpl
974 the insurance eob does not correspond to this claim. Please resubmit with correct eob attached. For info
call 1-800-562-6136.
975 professional/technical component for this procedure has already been paid to same/different provider.
976 fluoride and fluoride varnish not paid in combination.
977 insurance eob does not contain the denial code with printed denial reason. Unable to process.
978 recouped at provider's request used on adj - keep
979 dates of service fall within settlement dates. Contact aging and adult services administration at (360)
407-0654 for further information.
980 no insurance eob attached. Resubmit with remittance report, insurance eob, or appropriate comments.
For questions, please call the third party resource program @ 1-800-562-6136.
981 this is not a valid insurance denial/insurance comment. This covered service cannot be billed to the
client. If you have any questions, call 1-800-562-6136.
982 insurance company's requests must be met. If any questions call 1-800-562-6136.
983 detox services must be billed using a detox provider number.
984 reimbursement for this item is included in the facility per diem rate 301,365.432
985 A report is required to substantiate the fee for service billed. Please attach report and resubmit. Mrs
988 provider did not accept assignment with Medicare. Unable to process claim.
989 total of Medicare's paid, deductible, co-insurance and 3rd party is greater than amount billed to
Medicare. See billing instructions, verify money from Medicare remittance, correct claim and resubmit.
990 this provider number is invalid for this service. No ecp certification on file.
991 this claim cannot be adjusted as the icn is invalid or missing.
992 According to aging and adult services administration the per diem rate has been corrected. Nh adj
993 this psychiatric claim is beyond the pas length of stay allowance. Please contact your regional support
network (rsn) representative.
994 the report does not justify payment for services billed. Res, 053. Exam, 343
995 the claim lacks a report to justify a higher fee. Asu
997 retro ssi eligible. Mhc retro ssi recoupment
998 prp adjustment--adjudicated per prp review. Info
999 the dept cannot determine primary coverage as Medicare/managed care or a Medicare supplemental
policy. Resubmit indicating the primary payor, co-pay, and co-pay amount on claim comments or
backup. Loc 55.